BECKER'S
Hospital Review
BUSINESS & LEGAL ISSUES FOR HEALTH SYSTEM LEADERSHIP

Hometown Healthcare Isn't Dead: Why (Most) Smart Community Hospitals Can Still Thrive

Written by Jim McLaughlin | May 28, 2013

Community hospitals sit on fertile ground, some experts say, because while the latest iteration of value-focused healthcare has urban tertiary systems in a tizzy, the hospitals with the smallest patient populations have been practicing their version of the population health since their foundation.

Hidden strengths

Community hospitals, those in secondary markets without a teaching program, are often written off by larger systems due to their size, but when it comes to the triple aim of higher quality, greater patient engagement and lower cost, "they may have something to teach the big guys," says Joe Lupica, chairman of Newpoint Healthcare Advisors.

For one thing, they have the ability to achieve low costs. "Even if a small hospital's cost per discharge looks high, the problem may be in the denominator of volume, not the numerator of cost. The essential chassis delivers efficient throughput. Community hospitals have greater control over patient engagement, too, he says. "They have always been closer to their patients, who are also their neighbors. Engaging patients is no great revelation to them. My brother-in-law's small-town surgeon stopped by the house after work — with a pizza — to see how he was recovering. The surgeon didn't need a consultant to tell him about patient engagement." Additionally, today's enhanced quality measurement tools can evaluate community hospitals on equal footing with tertiary hospitals, rather than in previous decades when hospital rankings were based on features like size, volume and even "board members' social status," Mr. Lupica says. "Now a small community hospital can surprise the whole region by coming out with great quality scores and great HCAHPS scores [for patient satisfaction]."

Still, many speculate that standalone community hospitals will be overcome by the tide of mergers and operating agreements with large systems, Mr. Lupica says, even when they show healthy margins. "People are pushing so hard on rural hospitals to merge. It's odd, actually, that this is the time people would say to take the jump [into a transaction], when there are so many tools that make issues like geographic isolation less relevant," he says. "What a shame it would be for rural hospitals to reach their sunset, just as we've reached the sunrise of technology."

Staying solo

Not all hospitals want to, can or should remain independent, Mr. Lupica says, but if they do decide to merge, they should be picky when it comes to finding the right partner. "You can say no a thousand times, but you only get to say yes once," he says.

Mike Williams, president and CEO of Community Hospital Corporation, a consulting and management firm for smaller market hospitals, says community hospitals overall are "absolutely" in healthy shape right now. He agrees many can remain independent, so long as they meet three criteria:

1. They are geographically essential.
2. They are financially efficient.
3. They meet quality outcomes of the top 25 percent of hospitals.

Meeting these metrics greatly increases a hospital's likelihood of remaining independent or its appeal and value for potential acquirers and partners, Mr. Williams says.

For hospitals in states that chose not to expand Medicaid coverage under the optional provision of the health reform law, Mr. Williams says many disproportionate share hospitals will either close or operate on margins less than one percent if Medicaid DSH payments are slashed. "Of those that have been dependent on those protections, some will be doomed," he said. Even those with good cash on hand will run out of money eventually if they don't execute a strategy to stay in the black.

Winning strategy

Perhaps the most important piece of any community hospital's strategy is recapturing patients lost to competitors, says David Pederson, JD, board chairman of Great Plains Regional Medical Center in North Platte, Neb. His hospital, after learning community members were driving hundreds of miles away to have cardiac stents put in, completed a feasibility study and began its own cardiology program, which has provided more convenient and cheaper care for patients and increased the hospital's revenue. "We start by asking ourselves what do we need in this area, what can

we afford and what can we do well," Mr. Pederson says.

Great Plains has grown its medical staff in the last six years from about 50 physicians to 90 today, about half of whom are employed, Mr. Pederson says. The hospital has been fortunate to attract and retain a large number of international physicians, but recruitment has gotten more difficult with time. "We're in an area where hunting and fishing used to be the main appeal for [physicians] coming out of school. Now we find we need more equipment and investment in our facility to attract new physicians," he adds.

Patients want to see capital improvements at hospitals as well, Mr. Pederson says. Great Plains is undergoing a $100 million construction project that will reduce its 120-beds by adding more single rooms, but will increase capacity for outpatient care. "The advice everyone's giving is 'stay away from brick-and-mortar investments,' but what we find is that people need to feel they're getting their care from a state-of-the-art facility," he says. The project is necessary for several reasons, including as a way to market the hospital as a place to receive top care quality to an audience of patients who've become used to driving more than 100 miles to get to urban tertiary centers they see as more sophisticated.

Those capital investments are currently among community hospitals' greatest challenges, Mr. Williams says, since many have lagging financial indicators and have allowed their equipment and facilities to become outdated. That makes creditors leery to lend money the hospitals need to make improvements that would improve their credit ratings.

"They'll never achieve credit worthiness to access capital without the fundamentals," Mr. Williams says. Even for hospitals that don't intend to remain independent, he adds, "no matter what, you've got to be operationally focused so you'll be attractive for someone else to buy. [Community hospitals] should be evaluating their revenue cycle, supply chain and competitive operational productivity to see if they're performing in the top quartile. And if they're not, what must they do to perform there? Those operational things are the only things that will get them back to a solid bottom line."

Well positioned

Mr. Lupica says community hospitals' nimbleness to adapt to change is their greatest asset moving forward. At one of his client hospitals, the chief nursing officer, who used to work at a big urban system, told him "We can get things done here before my old place would have had four of the 17 signoffs they needed to make a decision."

"Community hospitals have been more enlightened about community than they even realize in the way they deliver efficiency, clinical outcomes and patient engagement," he says.

Much shorter waiting times at some community hospitals is an underestimated selling point, Mr. Williams says, and can be a powerful message to convince patients accustomed to waiting at other hospitals to stay local.

He also cautions against physician employment contracts that rely too heavily on historic and market-based compensation rather than on productivity. "Community hospitals are making big mistakes for the future when they acquire specialists in the marketplace who will be reimbursed less after changes take effect in healthcare reform," he says. Physicians may be seeking employment as a safe haven from those reimbursement cuts, and hospitals should stick to their guns when physicians say they'll go to competitors, he says.

Mr. Pederson advises that community hospitals place an equally strong emphasis on non-physician staff satisfaction, because medical professionals such as nurses are just as difficult to recruit and are essential for a cohesive, efficient and patient-pleasing environment.